# Strategies for a Smoke-free World

*A Report of the International Workshop on on Smoking and Health*

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and
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In co-operation with
**The World Health Organization Program on Smoking and Health**

At the request of
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The opinions expressed in this report do not necessarily reflect the policy of the organizations involved in conducting the Workshop.

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## Introduction

In 1980, the Board of Directors of the International Council on Alcohol and Addictions (ICAA) concluded that tobacco should be included within the Council's mandate. However, the Council was able to devote few resources to the tobacco problem prior to the 34th International Congress on Alcoholism and Drug Dependence,[1] held in Calgary, Canada, in August 1985. The 34th Congress provided the opportunity to initiate a more active program.

Tobacco's addictive properties legitimize involvement of the International Council on Alcohol and Addictions with tobacco issues. Moreover, these properties lend urgency to the need for intervention by all specialized addiction agencies. The addictive properties of tobacco cause people to continue smoking, even when they recognize the health consequences and would like to stop. Since few people smoke in moderation, there are inevitable and usually serious health consequences for virtually all users. Non-users exposed to tobacco smoke are also at risk.

The highly addictive nature of tobacco, which has been underemphasized in the past, has both policy and program implications. In policy terms, it raises the ethical question of whether or not governments should allow multinational conglomerates to seek new markets for tobacco products. In program terms, it highlights the critical importance of prevention and the likely difficulty of stopping smoking. Nevertheless, the workshop considered it important to emphasize that millions of people can and do quit smoking, most of them on their own. Unfortunately, many more do not.

With this in mind, a four-day International Workshop on Smoking and Health was convened immediately prior to the 34th Congress. It was organized at the request of the International Council on Alcohol and Addictions by the Health Promotion Directorate of Health and Welfare Canada and the Alberta Alcohol and Drug Abuse Commission, in co-operation with the World Health Organization Program on Smoking and Health. Recognized experts from around the world were invited to participate in the Workshop (see *Participants in the Workshop*).

For more than two decades the tobacco control problem has been the subject of active discourse and analysis at the international and national levels. Organizations such as the World Health Organization (WHO), l'Union Internationale Contre le Cancer (UICC), and the International Union Against Tuberculosis (IUAT), have made major contributions to these efforts. Conscious of this, the workshop approached its task in a way that would build on past strengths and make an additional contribution to world-wide efforts to reduce tobacco use.

This report of the workshop is not a verbatim record of the proceedings, but rather an attempt to capture the tone of the discussions and to synthesize the major themes. It is written with three purposes in mind:

1. To further define the issues in tobacco control from an international perspective;

2. To foster political will to act on these issues; and

3. To identify ways that the International Council on Alcohol and Addictions, and other addictions agencies, can contribute to tobacco control, in collaboration with other organizations and groups.

The report[1] is organized around three themes that reflect the thinking of the workshop participants.

Firstly, *the health consequences and epidemic significance of tobacco use need no further debate*. It is time to recognize that the real issues impeding the success of tobacco control programs are apathy, conflict and unethical marketing practices.[2] These issues are addressed in the first part of this report.

Secondly, *there are effective ways of controlling tobacco use*. For those countries that have adopted strong, comprehensive programs, smoking has leveled off or declined. The second part of this report offers practical examples of successful strategies.

Thirdly, *tobacco use has become a global health issue*. Cigarette consumption, while declining by about one percent a year in industrialized nations, is rising almost three times as quickly in the developing world. Increasingly, the giant transnational tobacco companies are seeking out Third World markets to replace the falling number of consumers in the developed countries. If this exploitation is to be curbed, international agencies must co-ordinate their efforts to raise political and public consciousness of the smoking problem in the global arena.

In addition to this report, the detailed recommendations from the Workshop to the Board of Directors of the International Council on Alcohol and Addictions, and a collection of selected resource papers prepared specifically for the Workshop are separately available (see *Related Documents*).

**Smoking: "Public Health Enemy No. 1"[3]**

During the 1950s, evidence began to mount concerning the increased risk among smokers of premature death from lung cancer. Smoking was soon shown to be a risk factor for a wide range of conditions, including upper respiratory infections, chronic bronchitis, emphysema, other cancers and cardiovascular disease.

This evidence was critically evaluated in a series of reports from the United Kingdom's Royal College of Physicians (1962[4] and 1971[5]) and the United States Surgeon General (1964,[6] 1972[7] and 1979[8]). Each report concluded that the relationship between smoking and disease was a causal one.

In the 1970s the hazardous effects of "sidestream" smoke on the health of non-smokers was first identified. Since then, numerous well-documented studies have described the harmful effects of involuntary smoking on the health of the fetus, infants, children, and adults who are regularly exposed to sidestream smoke.

As a result of these findings, world-wide awareness of the urgent need to mobilize a response to the smoking problem began to grow. The early calls for action evolved into comprehensive analyses of the strategies needed to control tobacco use. L'Union Internationale Contre le Cancer published *Influencing Smoking Behavior*[9] in 1969 and *Guidelines for Smoking Control*[10] in 1980. In 1975,[11] 1979[12] and 1983,[13] the World Health Organization expert committees published reports detailing possible governmental strategies in tobacco control. Each report was characterized by a steady escalation in the strength, scope and urgency of recommendations for the control of tobacco and the reduction of tobacco smoking.

World-wide, over 2 million deaths a year are associated with tobacco use. The incidence of disability and death has reached epidemic proportions in the United States, where it is estimated that some 350,000 people die each year as a result of smoking. In the United Kingdom deaths from smoking are estimated to number 100,000 each year. Despite recognition of this by the World Health Organization and its statement that smoking is "probably the largest single preventable cause of ill health in the world today",[14] the smoking epidemic has spread rapidly to the developing nations. In these countries the increased incidence of disease and premature death related to smoking has paralleled the rise in the consumption of cigarettes. Yet this is but the tip of an epidemiological iceberg. Due to the latency period for tobacco-induced illness (20 years plus, in the case of lung cancer), the incidence of tobacco-related health problems will rise even more dramatically in the future.

Despite these grim predictions, there is reason to believe that concerted action by all concerned bodies, including the appropriate international agencies, will reduce tobacco's toll[15] *(see Figure 1)*.

Figure 1 *Example of the transfer of tobacco advertising images typical of marketing efforts in Western nations to non-Western nations.*

## Recognizing the Issues of Concern

At the heart of the smoking problem lie political apathy and a massive imbalance of power. The organized activities of the tobacco industry and its diverse allies provide a startling contrast to the relative inactivity and lack of organization of those who could play a part in reducing smoking. This section directs attention to this concern and to other emerging global issues in tobacco control that were identified by the workshop participants.

### The Imbalance of Power

*The Transnational Tobacco Conglomerates*

There can be no doubt that the profit interests of the multinational tobacco companies present a formidable obstacle to a smoke-free world.

> "By presenting itself to the world as a creator of wealth, a source of revenue, the supplier of jobs, the bringer of development, the provider of pleasure, the patron of the arts and the defender of freedom, the tobacco industry has successfully diverted political and public attitudes from the real issue at stake: that the products from which all these benefits flow, have wiped out more people than all the wars of the last century".[16]

Not only is the multinational tobacco industry far better mobilized than the international health agencies, but the combined resources at its disposal vastly outweigh those of the health agencies. Each year, the transnational tobacco conglomerates spend over $2 billion to promote their products. While the industry denies that its massive advertising campaign is designed to entice people to begin smoking, much of its marketing efforts in the developed countries appeal to new consumers, particularly women and young people. In the Third World, advertising links cigarette use with sophistication, manliness, femininity and upward social mobility in ways which would never be permitted in most developed countries.[17]

These aggressive marketing practices are particularly inappropriate in the face of the incontrovertible evidence that smoking kills people—a fact that the industry continues to deny.*(See Figure 2).*

The direct and indirect lobbying pressure exerted by the transnational tobacco conglomerates is both powerful and pervasive. In addition to its influence on the media, national sport associations and cultural organizations, the industry seeks to influence tobacco research through its substantial financial contributions (in excess of $70 million in the United States alone).

Judging by its past marketing and advertising practices and its active opposition to legislative controls, one may reasonably expect the industry to continue to make every effort not only to promote its products, but also to prevent or undermine smoking control programs.

*Inadequate Government Response*

Considering the magnitude of the smoking problem, it is clear that the responses of governments and health agencies have been inadequate. Most remain under-funded and uncoordinated. Poor organization, a lack of resources and fragmentation continue to be major obstacles to effective intervention in one of the world's most preventable health hazards.

# The science of selling cigarettes.

It goes something like this.

You manufacture a product that a lot of people want to buy. Unfortunately, the leading scientists in the country say the product is a health risk.

To make matters worse, people are dying.

That doesn't do much for your corporate image. So you decide to do something about it.

First, you begin running a very provocative series of advertisements.

In those ads, you use the word "controversy" to imply that there's still some question about the link between cigarette smoking and heart disease.

Then you tell the public it's your responsibility to enlighten them so they can make their own informed decision.

Finally, you present research results and statistics that support your point of view.

In short, you cover your bases.

## A well-known fact.

And a simple one: Advertisers don't say bad things about their products.

They also don't "lie" — because the law won't let them. Which means that if someone else says something bad about their product, they look for a way to paint a prettier picture. And if that means grabbing at straws, they'll take the biggest one they can get their hands on.

That's what one tobacco company recently did.

They zeroed-in on the Multiple Risk Factor Intervention Trial (MR FIT). Conducted from 1972 to 1982, MR FIT was a study of almost 13,000 middle-aged men considered high risks for heart attack because of high blood pressure, high blood cholesterol, and cigarette smoking.

Over the course of the study, half the men received special attention intended to reduce those three risks while the other half received only normal medical care.

Result? Only a 7% difference — not statistically significant — in the number of heart disease deaths between the two groups.

If you're a tobacco company, you couldn't ask for a happier ending.

You could, however, tell the rest of the story.

Namely that during the 1970s the entire US population reduced its risks due to increased awareness of heart disease. And the men in the experiment — including the ones who didn't receive special medical attention — were no exception. Many of them stopped smoking. They changed their eating habits. And they kept closer tabs on their overall health.

The simple truth of the MR FIT matter is that at the end of the study, *both groups had reduced their risk of heart disease.* So naturally, and not surprisingly, the number of heart disease deaths between the two groups was not significantly different.

Oh yes, one more bit of information about MR FIT that might have been overlooked: the men who quit smoking (in both groups) had a coronary death rate *almost 50% below* that of those who kept smoking.

## The truth prevails.

It also hurts sometimes. It can be especially painful when it threatens sales.

At the American Heart Association, we have nothing to gain by presenting partial truths. We have no motive other than that of improving the quality of life.

And we have no need to grab at straws when we hold in our hands the Surgeon General's Report which contains hundreds of studies establishing the link between smoking and heart disease.

What we do have at the American Heart Association is a problem with advertising that's disguised as an impartial report. With ulterior motives that take on the appearance of genuine concern. And with irresponsible ads that show little respect for public intelligence and even less for human life.

That's the science of selling cigarettes.

WE'RE FIGHTING FOR YOUR LIFE

American Heart Association

Figure 2 *The tobacco industry published a series of advertisements in influential magazines in an attempt to discredit the evidence linking health hazards to tobacco use. The American Heart Association countered with the advertisement shown above.*

Government complacency has contributed to a failure to develop alternative marketable crops that do not carry the health and social costs of tobacco.[18] In spite of increasingly strong recommendations from the World Health Organization, countries which introduce comprehensive anti-smoking policies and programs remain the exception.

This political apathy may be partly explained by two factors: the financial conflict inherent in government's relationship with tobacco, and the fact that the deleterious health and environmental effects of tobacco do not always manifest themselves immediately.

Tobacco offers attractive fiscal benefits in the short term. It provides agricultural income, jobs and a readily available source of taxation revenue. This may be particularly alluring to hard-pressed Third World governments facing chronic inflation, unemployment and food shortages. In the long term, however, the massive economic and social costs of tobacco outweigh its immediate benefits.

Aside from the obvious cost of health care for victims of tobacco-related disease, the environmental cost of growing tobacco is also an important concern for developing countries. In Tanzania, for example, about one hectare of forest is required to cure one hectare of tobacco. Thus, developing countries must ultimately deal with a serious firewood shortage and the accelerated desertification of land that is desperately needed to grow food.

Expedient political decisions taken today may have grave consequences some two decades later. Dealing with the smoking problem requires a clear acceptance by government of its responsibility for the health of its citizens and the consistent exercise of political will.

**New and Previously Neglected Tobacco Issues**

Although there has been progress in recent years, in most countries the public remains under-informed about the magnitude and implications of the smoking problem. Specifically:

- Throughout the world over two million people die prematurely each year because of cigarette smoking. Authoritative projections could be a useful aid to the presentation of this information. By the same token, there is an urgent need to stress the long-term benefits to society if smoking rates can be brought down.

- Because tobacco is viewed as a legitimate consumer commodity, it remains exempt from the safeguards usually associated with the distribution and promotion of harmful products. Unfortunately, it is not commonly appreciated that tobacco is a highly addictive substance whose long-term adverse effects are at least as costly as those of alcohol and illicit drugs. Surveys have shown that most smokers would like to quit, but can't. Among those who do quit, 70 percent resume the habit within three months—about the same recidivism rate found with heroin dependence.

- Contrary to the assertions of the industry, there is no such thing as a "safe" cigarette. Modified tobacco products (for example, those with lower tar and/or nicotine yields) represent a questionable advance. Many smokers of low-yield cigarettes, in fact, increase their nicotine dose by smoking more. Also, young people may find it easier to begin smoking with low-yield "milder" cigarettes. Moreover, the sidestream smoke from "low-tar" cigarettes yields higher levels of toxic constituents than the sidestream smoke from regular-tar cigarettes.

- Consumers have a right to be protected from products that are demonstrably harmful. In light of the evidence on sidestream smoke and the strongly addictive nature of tobacco, the transnational tobacco conglomerates apparent concern for personal freedom and the right of individuals to make their own lifestyle decisions rings somewhat hollow. In fact, the non-smoker's right to clean air and freedom from pressure to buy products that are noxious and harmful, would appear to be beyond dispute.

**Absence of Reliable Data and Program Research**

Data collection and program research are essential for the design of an effective smoking control program. Several important knowledge gaps in these areas have been identified, including:

- an absence of local statistics on the prevalence and incidence of tobacco use and its health consequences, or the inability, in some cases, to adequately analyse this data. This is particularly problematic in developing countries;
- a scarcity of data on the impact of smoking on children;
- insufficient evaluation both of the efficacy and cost-effectiveness of anti-smoking measures;
- an incomplete understanding and use of economic strategies, including taxation and crop substitution; and,
- an insufficient number of studies that investigate the incidence of worker absenteeism or poor productivity due to smoking-related disease.

If governments and non-governmental organizations are to design effective countermeasures and preemptive actions, it is vital that they familiarize themselves with the policies, strategies, research and marketing programs of the tobacco companies. Much of this knowledge is readily accessible through tobacco trade journals and other public sources.

In addition, research efforts that have tended to be largely medical in the past need now to be redirected toward the practical implementation of smoking control measures.

**Spurious Remedies**

Effective action to control smoking has often been limited and weakened by the acceptance of "spurious remedies"— compromises usually designed to prevent or obscure the need for stronger and more effective action. For example:

- The implementation of token or partial programs may be counterproductive if they are used by governments to imply that further action is not necessary. For example, it is tempting to conclude that legislation alone will suffice to control smoking. In fact, legislative action will only be effective when complemented by adequate public education activities. Similarly, education programs have more effect when backed by legislative strategies. This point is amply illustrated by experience gained with other addictive substances.
- The traditional use of low-key, poorly funded information and education programs is no longer an appropriate response to the massive problem of tobacco use. There must be a substantial

injection of educational resources if meaningful results are to be attained. Effective education program models already exist in several countries. These can be adapted by developing countries to better suit their needs. Equally important is the need to maintain the current impetus and innovation in educational programs throughout the world.

- While "stop-smoking" programs perform a valid function, they have tended in the past to claim an unduly large proportion of the limited resources available for smoking control. These programs should complement and not replace legislative and preventive activities.

- While voluntary advertising codes with the tobacco industry may appear attractive to governments, experience around the world has demonstrated that the industry consistently abuses them. Legislation has proved to be the only effective way to control the marketing activities of the transnational tobacco conglomerates.

The imbalance of power, the need to emphasize new issues related to tobacco itself, the absence of reliable data and the acceptance of spurious remedies are the major problems in tobacco control. Although grave, these issues can be dealt with through the adoption of policy statements such as those endorsed by the World Health Organization, l'Union Internationale Contre le Cancer and the International Union Against Tuberculosis *(see World Health Organization Policy Objectives)* and the implementation of effective tobacco control strategies. This is the subject of the next section.

**Strategies in Tobacco Control**

Some say that the achievement of a world free of tobacco smoke is a naive and impossible dream; others believe that it is an attainable goal worth striving for. What is clear is that success in smoking control depends, above all else, on a comprehensive approach that provides for a mix of strategies that strengthen and reinforce each other. Three major strategies have been clearly described in expert committee reports from the World Health Organization and adopted by such international organizations as l'Union Internationale Contre le Cancer and the International Union Against Tuberculosis. They are:

- legislation,

- information and education, and

- economic intervention.

When deliberately initiated together, these strategies can have a synergistic effect. A public that is educated about the issues is more likely to be receptive to legislative or regulatory measures. Economic measures such as increased taxation reinforce the informed consumer's motivation to quit smoking. Crop substitution programs offer tangible support to tobacco growers who may be quite willing to diversify if this is economically feasible.

In this section the three major strategies in tobacco control are described and illustrated with selected examples of countries that have implemented them. The references are far from definitive since space does not permit the mention of even a representative sample of countries which actually employ each strategy.

## Legislation

A government puts itself clearly on the side of health by setting forth restrictive policies in legislative form on the production, promotion and use of tobacco. Six legislative options are presented in this section. Taxation, an important seventh option, is discussed under economic intervention.

*Freedom from Tobacco Promotion*

Efforts to control tobacco advertising are becoming increasingly common. Among 64 countries known, in 1982, to have national legislation to restrict smoking, 54 had enacted controls on advertising.[19] Total bans on advertising have been enacted by Jordan, Singapore, Spain, and a number of other countries. In Finland, Iceland, Norway and Mozambique, the ban is one part of a comprehensive smoking and health program.

The feasibility of regulating a total advertising ban varies with differences in legal systems and the extent of foreign media influence. While some nations have passed strong partial bans, these are often subject to evasion by the industry. Moreover, the industry continues to advertise, despite bans, through extensive sponsorship of sports and cultural events. In this manner, harmful tobacco products are promoted to millions of people in the context of life-enhancing athletic and artistic activities. Only a total ban that includes advertising and sponsorship programs will leave young people free to grow up unswayed by advertising that equates smoking with success. In Norway, attempts to circumvent the advertising ban, have been effectively stopped through legislation *(see Figure 3)*.

Figure 3 *From top to bottom: typical Camels cigarette advertisement; first attempt by industry to market Camel "Boots", second attempt—after first attempt banned, third attempt.*

*Health Warnings*

While some of the 40 countries that have legislated health warnings are in developing areas, many Third World nations have no legislation. As a result, exported tobacco products are often marketed in developing nations without the health warnings that are required in the exporting countries.

Several countries have recognized the effectiveness of rotating warnings, such as those used in Sweden. These warnings contain strong, specific messages that are alternated periodically. In the United States, four rotating warnings are now required on cigarette packages and all tobacco advertising. These are:

**Surgeon General's Warning:** Smoking causes lung cancer, heart disease, emphysema, and may complicate pregnancy.

**Surgeon General's Warning:** Quitting smoking now greatly reduces serious risks to your health.

**Surgeon General's Warning:** Smoking by pregnant women may result in fetal injury, premature birth, and low birth weight.

**Surgeon General's Warning:** Cigarette smoke contains carbon monoxide.

Iceland has taken health warnings one step further by requiring tobacco products to carry a printed health warning and one of six illustrations *(see Figure 4)*.

*Product Modification*

The effectiveness of legislation as a way to reduce average tar levels in cigarettes is illustrated by Egypt, where the maximum level for tar was set by law at 20 mg. One year later, five major brands of cigarettes

1. Smoking during pregnancy endangers the health of mother and child.

*DIRECTOR GENERAL OF PUBLIC HEALTH*

2. Smoking may damage your arteries and cause heart attack.

3. Protect children from tobacco smoke.

4. If you stop smoking you improve your health and increase your life expectancy.

5. Smoking is a health problem you can help to solve.

6. Hundreds of Icelanders die each year due to smoking.

Figure 4 *Six health warnings required by Iceland on cigarettes on a rotating basis.*

had reduced their tar content to levels ranging from 15.5 mg. to 17.9 mg.[20] Finland and Kuwait have also legally mandated upper limits of yield of harmful substances such as tar, nicotine and carbon monoxide.

A cautionary note should be added when considering product modification. Experience in industrialized countries has shown that the tobacco industry consistently uses low-yield cigarettes to justify its marketing strategies. Government should allow the industry no opportunity to claim that low-tar cigarettes are approved or safe. They are neither.

*Restrictions on Sales*

People have come to take the wide and ready availability of tobacco products for granted. By imposing restrictions on the locations where cigarettes may be sold, governments can make a strong statement to their people. Tobacco, if it is to be sold at all, should be sold in such a way as to indicate to the public that it is a very dangerous commodity, to be treated with great care, not pushed on others, and given up at the earliest possible moment. Policies limiting the availability of tobacco products help to make this clear.

Finland has restricted the use of cigarette vending machines to catering establishments where they are under constant supervision.[21] A 1983 Brazilian law, in the state of Rio Grande do Sul, bans and penalizes the sale of cigarettes in any establishment subsidized by the government, including the Legislative Assembly.[22]

Many countries have laws prohibiting the sale of tobacco to minors. The enforcement of these laws varies from country to country, but is generally not effective. Iceland's legislation, enacted in 1984, is perhaps the best model of a law designed to prevent young people from smoking. In that country, tobacco may not be sold to persons under 16 years of age; all sale of tobacco from vending machines is prohibited; and, tobacco may not be given to children or sold in schools or institutions for children and young people.[23]

*Restrictions on Smoking in Public Places*

From 1982 to 1985 the number of countries restricting smoking in public places (for example, enclosed cinemas, public transportation vehicles, elevators) has risen from 31 to 37. While most designate specific "no smoking" areas, Finland's unique legislation establishes a non-smoking norm by prohibiting all smoking in public places unless specifically allowed. Over 30 states in the United States have laws restricting smoking in public places. In some states, this includes restrictions in the workplace. The Minnesota Clear Indoor Air Act serves as a model of this type of legislation.

*Health Education*

Legislation in Finland and French Polynesia dedicates a portion of tobacco tax revenue to health education and non-smoking initiatives. In the United States, the state of Texas has mandated the inclusion of a "peer-assisted non-smoking program" in school curricula.

In the battle against smoking, legislation provides an arsenal of effective weapons. Convincing legislators to act, however, requires an education campaign, support for citizen action and sensitivity to public opinion. Education, the second strategy recommended in the World Health Organization reports, provides the basis for motivating such action.

## Education and Information Programs

Public education and information programs strengthen the "non-smoking" environment and offer support for behavior change. Three aspects of a public education initiative are particularly important:

- media promotion,
- "stop-smoking" programs, and
- prevention programs.

*Media Promotion*

Most of the world-wide media coverage on the hazards of smoking in the 1960s was stimulated by reports from the United Kingdom's Royal College of Physicians and the United States Surgeon General. Various smoking control groups, including Action on Smoking and Health (ASH), were very effective in their efforts to focus media attention on the tobacco and health issues raised in these reports.

Today, promotion using a variety of media can "sell" the desirability of a non-smoking environment. A particularly effective technique is the use of exemplary role models both as non-smokers and ex-smokers. Venezuela is one example of a country with this type of campaign. It is spearheaded by a group of prominent physicians.

*"Stop-smoking" Programs*

The use of public education techniques to encourage smokers to quit has been effectively demonstrated by three large community projects. In Canada, the United States and the North Karelia region of Finland, television has been used as one component of a large-scale "stop-smoking" program. Canada also has a popular program which involves the use of family physicians to counsel patients on how to stop smoking.

*Prevention Programs*

It is more cost-effective to deter young people from starting to smoke than to attempt to change the dependency of adults who already smoke. This conviction is reflected in the growing number of countries implementing prevention programs. Recent findings in a large-scale in Japan confirm the importance of this strategy.[24] According to this study, starting to smoke before age 20 exposes people to higher mortality rates irrespective of the number of cigarettes smoked daily.

Australia, Canada, Finland, Sweden, the United Kingdom, and the United States are examples of countries with exemplary prevention programs. They are based on long-term plans that allow for continuity, evaluation and the design of programs that reflect sound research findings. For example, recent studies have shown that two effective components of a prevention program are peer teaching and role playing as a means of learning to resist social pressures to smoke. Prevention strategies developed to deal with other addictive substances are worth considering for possible application in the tobacco field.[25]

## Economic Intervention

Monetary issues are central to a comprehensive campaign against the cultivation of tobacco and the manufacture and sale of cigarettes. Economic strategies that address these concerns include policies directed at supply management (crop and

market substitution, raised prices), and demand reduction (increased taxation).

*Crop and Market Alternatives*

Up to now, no country has undertaken an assertive crop substitution program. The Food and Agricultural Organization (FAO) should lead the way by initiating projects which demonstrate the feasibility of crop substitution for tobacco. A successful crop change in actual practice could be a landmark in the battle of "health vs wealth" that continues over the issues of tobacco production.

Similarly, no country has yet been able to implement a program that assists retailers in replacing tobacco with alternative, equally profitable commodities. Though idealistic, this idea warrants further investigation. In Canada, 63 percent of all retail pharmacies have recently pledged support to a program that increases exposure of the "non-smoking" message and discourages pharmacists from selling tobacco products.

*Product Liability Lawsuits*

A recent legal verdict in Sweden compensated relatives of a victim of lung cancer caused by passive smoking. Similar litigation against the tobacco industry by a number of victims of cigarette-induced illness is currently pending in the United States. These lawsuits will be followed with interest around the world. Although there has been little success in the United States thus far, it is worth noting that a variety of different approaches are being tried. Should any one of these cases be successful, it would set a legal precedent for thousands of similar lawsuits. This could ultimately prove financially disastrous to the tobacco industry.

*Taxation*

Although some would argue that taxation revenues are a factor inhibiting government response to the smoking problem, there is convincing evidence that increasing taxes on tobacco products is one of the most powerful weapons in tobacco control. Like restrictions on the availability of tobacco products, controls on pricing speak to the fact that because they are dangerous, cigarettes should not be easy to obtain. Taxation on tobacco is also an acceptable way of having smokers pay for at least part of the additional health-care costs associated with their smoking-related diseases. In addition, and perhaps most importantly, price increases have been shown to influence the initial decision to take up smoking, especially among teenagers.

The inverse relationship between taxation and tobacco use is illustrated in the case of the United Kingdom. Five successive tax increases, from 1974 to 1978, were associated with a nine percent reduction in total cigarette sales. Many other countries have increased taxes on tobacco products. In 1983, Zaire tripled its taxes on cigarettes, even though they had been raised significantly in the preceding two years.[26]

Another use of tobacco taxation is that pioneered by Finland. In that country's national budget, one half of one percent of tobacco tax revenue is allocated for health education, research and evaluation in smoking control.[27] Likewise, in a 1984 law, Iceland legislated that two percent of the revenue from tobacco sales be spent on anti-smoking activities.[28]

## Breaking the "Smoke Ring"

The "Smoke Ring" has been described as the protective circle of political and economic interests that keeps the tobacco industry intact in the face of conclusive evidence that its products have contributed to the deaths of millions of its customers.[29] The circle is further strengthened by the industry's greatest ally—the nicotine to which many of its customers are addicted. Escape from the "Smoke Ring" is possible, however, as demonstrated by the progress made to date by several countries.

All successful tobacco control programs have one thing in common: the implementation of a *comprehensive* approach that includes measures of information, legislation and economic intervention as well as "stop-smoking" and prevention programs. While all these elements are deliberately used, the emphasis varies from country to country, depending on local cultural, legal and social norms, as well as upon the degree of political readiness for action.

This section describes comprehensive national programs that may serve as models for other countries. Programs which are not strictly speaking comprehensive, but combine a range of strategies, are also mentioned.

### The Scandinavian Countries

For many years the Scandinavian countries have led the way in tobacco control. Extensive information and education programs were pioneered by volunteer associations, and later expanded by government agencies. In the 1970s, Sweden and Finland added anti-smoking legislation and price increases to their education strategies. Around the same time, the Norwegian parliament established a government Council on Smoking and Health, increased educational activities, and implemented a comprehensive Tobacco Act.

In January 1985, Iceland enacted innovative legislation designed to have even more far-reaching effects. In the first quarter of 1985 the amount of tobacco sold fell about six percent. Consumption levels were reduced even further when an eight percent price increase took effect the following June.

In the Scandinavian countries the introduction of comprehensive programs has led to a stabilization, and slight reduction, in cigarette consumption. Stabilization in Norway occurred in spite of the fact that consumption levels there were already lower than those in other industrialized countries, such as the United Kingdom. Today in Norway, per capita consumption is at the level recorded for the United Kingdom more than 30 years ago.[30] Accordingly, lung cancer mortality rates in the United Kingdom are three to four times higher than in Norway. Because Norwegian consumption rates have steadied and begun to decline, it is likely that the incidence of lung cancer in Norway will never reach today's United Kingdom levels.

An indication of further public support for anti-smoking programs in Norway is the fact that, in 1985, a representative poll revealed that 81 percent of Norwegian adults were in favor of proposed new legislation stating that public places and work-sites shall be smoke-free.

The decrease in smoking rates among young Scandinavian men and women is particularly promising. If the observed trend continues at its present rate, Norwegian

adolescents could be "smoke-free" within a couple of decades *(see Figure 5)*.

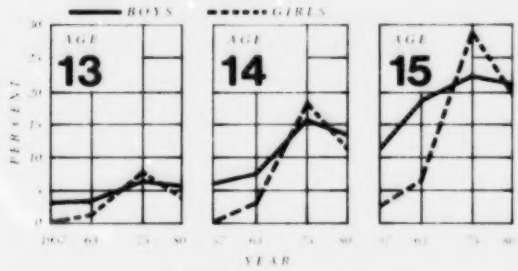


Figure 5. *Per Cent Daily Smokers, School Students, By Age and Sex, Norway, 1957, 1963, 1975 and 1980.*[31]

**Kuwait**

A comprehensive smoking control program in Kuwait includes the following activities:

- price increases through taxation;
- regulation of tar and nicotine limits;
- banning of tobacco advertisements in public places (for example, billboards);
- a co-ordinated information and education campaign;
- research on local smoking behavior; and
- the scientific analyses of imported cigarettes.

A special watchdog committee oversees the implementation of the smoking control regulations. The Kuwait Society For Smoking and Cancer Prevention (formed in 1980) co-ordinates the efforts of government and non-governmental agencies.

**Pakistan**

The Government of Pakistan has fully endorsed the World Health Organization policies on smoking and health. As part of an ongoing National Smoking Control Program, Pakistan has laid the conceptual basis for a comprehensive program by enacting the following measures:

- The "Cigarette Ordinance, 1979" provides for compulsory printing of health warnings in English and Urdu on both sides of cigarette packages.
- A public information campaign using television and radio was introduced in 1980.
- A partial ban (initiated in 1982) prohibits advertising of tobacco on television until 2130 hours daily. This is aimed at restricting young peoples' exposure to the promotional campaigns of the tobacco industry.
- A 1982 Presidential Directive prohibits smoking in hospitals, educational institutions, cinemas, libraries, trains, buses and other public places. The intent is to recognize "non-smoking" as the normal social behavior, and to acknowledge the serious health consequences of involuntary smoking.

### Brazil

Since tobacco is one of its top three export products, Brazil serves as an important example of how a nation that grows tobacco can still develop effective control strategies.

Brazil's anti-smoking campaign began in 1975 when a group of medical professionals launched a public information campaign. Fully aware that they could expect no legislative support from a federal government strongly dependent on the tobacco industry for exports, jobs and tax revenue, the doctors focused public attention on tobacco's harmful consequences for individual health and vigor, as well as on the deleterious long-term effects of smoking on Brazilian youth. As the message spread, the group gained support from local health leaders, education authorities and the media.

Today, a growing number of Brazilian politicians, particularly at the municipal and state levels, are joining the campaign. Local bylaws prohibiting smoking in public places are already numerous across the country.

### United States of America

The United States was the first country to require health warnings on cigarette packages. A number of states and municipalities have now established restrictions on smoking in public places (for example, Minnesota) and in the workplace (for example, San Francisco). While some restrictions on advertising have been implemented, the overall promotion of tobacco has not yet been perceptibly curtailed.

The United States provides an important example of the effective use of the public information strategy. The media attention given to the Surgeon General's Reports on Smoking and Health has increased public support for anti-smoking in the United States and around the world. The United States has also led the way in the development of educational techniques designed to prevent young people from starting to smoke, and of programs designed to help them resist peer pressure. In a few states, health education to prevent smoking is now mandatory, and some states (Texas, for example) have established substantial funds for the implementation of new educational programs. "Stop-smoking" programs, such as the "Great American Smoke-Out" sponsored by the American Cancer Society, are also well-established.

The American tobacco industry remains a powerful national and international force opposing anti-smoking efforts. Consequently, although limited taxation measures have been implemented, the price of tobacco has remained relatively low. However, increased state excise taxes and rising manufacturing costs appear, in 1985, to have at last begun to exert downward pressure on total consumption levels. In addition, new legislation makes health education measures and rotating health warnings mandatory, and requires manufacturers to supply information on tobacco additives to the government.

### Mandates for International Action

Several expert reports issued by the World Health Organization and l'Union Internationale Contre le Cancer have formulated international programs to curb the tobacco epidemic. So, too, have the

resolutions of the Fifth World Conference on Smoking and Health, held in Winnipeg, Canada in 1983. Efforts to implement comprehensive programs, however, have been hampered by a lack of international co-ordination, insufficient funding and the lack of political will. If these problems are to be overcome, there must be a broader involvement in the smoking problem by both national and international health agencies.

The workshop identified five broad implementation strategies that could be acted upon immediately:

1. a summit meeting of relevant international non-governmental organizations;

2. co-operation among countries on a regional basis;

3. an international system of training bursaries to develop smoking and health expertise;

4. improved funding of international anti-smoking efforts; and,

5. a new commitment to finding economic alternatives to tobacco, using the resources of organizations in the United Nations family.

Discussion of these activities follows.

### A Summit Meeting of International Bodies

Several international bodies are currently engaged in tobacco control efforts. These include the World Health Organization, l'Union Internationale Contre le Cancer, the International Union Against Tuberculosis, the International Organization of Consumers Union (IOCU), and now the International Council on Alcohol and Addictions. A summit meeting of these organizations is desirable for two reasons: to better co-ordinate their activities and avoid duplication of effort, and to develop a strategy for the enlistment of further allies.

It is highly likely that other international bodies would join groups already working in tobacco control. For example, the National Academy of Sciences in the United States, which has international status, is already preparing for its entry to the field. In another encouraging move, the International Olympic Committee (IOC) and the World Health Organization have established a global program designed to encourage sport and health in a positive sense. A strategy to enlist the support of additional international organizations representing fields as diverse as medicine, sport, communication and religion, could be prepared at the summit meeting.

### Regional Co-operation

Regional co-operation is essential in an international effort to build a tobacco-free world. Latin America provides an example of the effectiveness of a regionally integrated approach.

In January 1984, with the support of l'Union Internationale Contre le Cancer, twelve countries already involved in tobacco control joined together to form the Latin American Committee for Smoking Control. The committee provides a forum for the active exchange of information on strategies and programs. In addition to strengthening existing campaigns, the committee aims to influence other countries and encourage the

initiation of new tobacco control programs throughout Latin America. The committee also collaborates with the Pan-American Health Organization (the regional World Health Organization office for the Americas) to integrate smoking control action in the area.

### International Bursary Programs

International organizations, both government and non-governmental, often provide fellowships, bursaries and grants for training in a wide range of medical and scientific endeavors. As yet, no program of this kind exists in tobacco control. Fellowships, bursaries and grants would enable individuals to pursue careers in the co-ordination of national, regional and local non-smoking programs. The World Health Organization, l'Union Internationale Contre le Cancer and the International Union Against Tuberculosis are examples of international bodies that could create these funding support mechanisms. This would allow all countries, particularly those in the developing world, to acquire trained human resources for ongoing efforts to achieve a smoke-free environment.

### Funding of Anti-Smoking Efforts

Unfortunately, the level of resources allocated to anti-smoking efforts by health organizations often bears no relationship to their policy statements on the magnitude of the smoking problem. Significant progress in the control of tobacco cannot be made unless adequate funds are provided for the implementation of the legislative, education and economic strategies outlined in this report. There are two approaches to the development of a financial resource base worth careful consideration.

*Budgeting for Tobacco Control*

Health organizations should allocate a budget to anti-smoking activities that is proportionately related to the health costs of tobacco. Epidemiological techniques have been established for estimating the proportion of preventable death and disease attributable to tobacco use. These could serve as guidelines for determining the proportion of spending for disease prevention that should be allocated to smoking control. Western Australia, which annually allocates a sum of $1.37 per capita for smoking control, serves as an example of effective budgeting for tobacco control.

*A World Tax to Save Lives*

A second useful approach to funding would be to have each government that professes support for anti-smoking activities allocate, to educational activities, funds equivalent to at least one percent of their tax revenues from tobacco. These funds would help to curtail tobacco use and eventually reduce governments' unhealthy dependence on tobacco revenues. This type of policy has been established in Finland, Iceland and French Polynesia and is under consideration in a number of other states and nations.

A portion of the funds raised should be allocated to domestic and international organizations that are concerned with tobacco control. For example, the Norwegian governmental aid program contributes to anti-smoking work in developing countries by providing funds to l'Union Internationale Contre le Cancer. If other countries allocated even as much as one-fifth of one percent of tobacco tax revenues to the efforts of the World Health Organization

and other appropriate international bodies, tangible progress could be made in the struggle to eliminate the harmful effects of tobacco in health and social areas.

### Responsibility of United Nations Family

Today, only one full-time officer in the World Health Organization is engaged in tobacco control. The World Health Organization headquarters should dramatically increase its resource allocation in this area. At the same time, it is recognized that the promotion of health depends on involvement from a wide range of governing agencies, not just from health authorities. This is true at both the national and international levels.

Accordingly, within the United Nations family, responsibility for the tobacco and health problem cannot be restricted to the World Health Organization alone. Other agencies also have a critical role to play in resolving the problem.

Some United Nations agencies have supported the expansion of tobacco production in the past. These programs should be reversed and new policies consistent with the achievement of tobacco control should be implemented.

The United Nations Conference on Trade and Development (UNCTAD) should continue to monitor and document the activities of the tobacco multinationals. The Food and Agricultural Organization (FAO) should discourage the cultivation of tobacco while initiating support for the exploration of viable crop substitution. The World Bank should assist in funding this project.

### Recommendations to ICAA

Participants in the International Workshop on Smoking and Health welcome the decision by the International Council on Alcohol and Addictions to become actively involved in tobacco control. The International Council on Alcohol and Addictions, with its addiction perspective and its impressive network of contacts, offers a significant opportunity to strengthen international efforts.

Based on this report, the Workshop has made fourteen specific recommendations to the Board of Directors of the International Council on Alcohol and Addictions. If adopted, these will mean a significant new role for the International Council on Alcohol and Addictions in the tobacco field. Four involve policy, seven concern strategy and three deal with research. Several state positions that the International Council on Alcohol and Addictions is asked to advocate in its relations with other bodies.

Although these recommendations are specific to the Board of Directors of the International Council on Alcohol and Addictions and will not be discussed further in this report, copies are available (see *Related Documents).*

### Conclusion

The Workshop accepts the epidemic consequences of tobacco use as an incontrovertible fact challenging world health. It recognizes that successful strategies exist—if the political will to put them in place can be asserted. The Workshop urges all countries of the world to activate that will by initiating comprehensive programs in tobacco control.

The entry of the International Council on Alcohol and Addictions to the international tobacco control field is a positive development. The Workshop members look forward to the contribution that an experienced addiction agency can bring. The Workshop members also have appreciated the assistance and support of the International Council on Alcohol and Addictions and the Workshop organizers.

## Footnotes

[1] The International Council on Alcohol and Addictions is an international non-governmental organization with consultative status (Category II) with the United Nations Economic and Social Council, and is in official relations with the World Health Organization. Among its functions is the sponsorship of the International Congresses on Alcoholism and Drug Dependence. The 34th Congress was held in Calgary, Canada in August, 1985. This Congress marked the 100th anniversary of these events.

[2] This rather strong statement is supported by an incisive analysis and indictment of the tobacco industry by Dr. Frederick Clairmont. Reference: United Nations Committee on Trade and Development, *Marketing and Distribution of Tobacco, Study prepared by the UNCTAD Secretariat*, Report No. TD/B/C.1/205 (Geneva: 1978).

[3] US Department of Health, Education, and Welfare, *Smoking and Health, A Report of the Surgeon General*, DHEW Pub. No. (PHS) 79-50066 (Washington: 1979). In the Secretary's foreword, Joseph A. Califano referred to smoking as "Public Health Enemy Number One in America".

[4] Royal College of Physicians of London, *Smoking and Health* (London: Pitman, 1962).

[5] Royal College of Physicians of London, *Smoking and Health Now* (London: Pitman, 1971).

[6] US Department of Health, Education and Welfare, *Report of the Advisory Committee to the Surgeon General of the Public Service* (Washington: 1964).

[7] US Department of Health, Education and Welfare, *The Health Consequences of Smoking, A Report of the Surgeon General* (Washington: 1972).

[8] US Department of Health, Education, and Welfare, *op. cit.* (Washington: 1979).

[9] J. Wakefield, ed. *Influencing Smoking Behavior*, Technical Report Series, Vol. 3 (Geneva: l'Union Internationale Contre le Cancer, 1969).

[10] Nigel Gray and Michael Daube, eds. *Guidelines for Smoking Control*, 2nd edition (Geneva: l'Union Internationale Contre le Cancer, 1980).

[11] World Health Organization, *Smoking and its Effects on Health, Report of a WHO Expert Committee*, Technical Report Series No. 568 (Geneva: 1975).

[12] World Health Organization, *Controlling the Smoking Epidemic Report of a WHO Expert Committee*, Technical Report Series No. 636 (Geneva: 1979).

[13] World Health Organization, *Smoking Control Strategies in Developing Countries, Report of a WHO Expert Committee*, Technical Report Series No. 695 (Geneva: 1983).

[14] Dr. Halftan Mahler, Director General of the World Health Organization, 1980.

[15] Elizabeth Whelan, *The Smoking Gun: How the Tobacco Industry Gets Away With Murder* (Philadelphia: George F. Stickly, 1984).

[16] Peter Taylor, *Smoke Ring—The Politics of Tobacco* (London: The Bodley Head, 1984).

[17] World Health Organization, *op. cit.* (Geneva: 1983).

[18] The Canadian Federal Government included resources for tobacco crop substitution initiatives for Canadian tobacco growers in its budget brought down in Spring, 1986.

[19] R. Roemer, *Legislative Action to Combat the World Smoking Epidemic* (Geneva: World Health Organization, 1982).

[20] Omar, et al., *Prevention of the Smoking Epidemic in a Developng Country (Egypt)*, CVD/SMO/EC/82.13/Rev. 1 (Geneva: World Health Organization, 1982).

[21] Finland, "Law No. 693 of 13 August 1976 on measures to restrict smoking", *International Digest of Health Legislation*, (hereinafter IDHL), vol. 28 (1977), 486.

[22] Brazil, "Rio Grande do Sul, Law No. 7813 of 21 September 1983 laying down provisions on smoking and other provisions", *IDHL*, vol. 34:4 (1983), 768.

[23] Iceland, "Law No. 74 of 28 May 1984 on prevention of the use of tobacco", *IDHL*, vol. 36:1 (1985), 41.

[24] T. Hirayama, "Non-smoking Wives of Heavy Smokers Have a Higher Risk of Lung Cancer: A Study from Japan", *British Medical Journal*, vol. 282 (1981), 183-185.

[25] J. Skirrow, *Primary Prevention—A New Approach to Adolescents and Alcohol* (Edmonton: Alberta Alcohol and Drug Abuse Commission, 1985).

[26] Zaire, "Ordonnance-Law n. 83 du 12 septembre 1983, modifiant l'Ordonnance-Loin. 68-010 du 6 janvier 1968, relative aux droits de consommation et au regime des boissons alcooliques, Journal of ficielde le Republique du Zaire, 24eme Annee, No. 18, 15 septembre 1983", *IDHL*, vol. 36:1 (1985).

[27] R. Roemer, *op. cit.*

[28] Iceland, *op. cit.*

[29] Peter Taylor, *op. cit.*

[30] Kjell Bjartveit, "Legislation and Political Activity", Fifth World Conference on Smoking and Health, Winnipeg, Canada, July 12, 1983. In, *World Smoking and Health*, vol. 8:3 (Autumn 1983),13-21.

[31] Source: *1957 and 1963*: These surveys were carried out in Norwegian schools. Sample sizes within each age/sex group ranged from 812 to 1,245 in 1957, and from 440 to 605 in 1963.

*1975 and 1980*: National Council on Smoking and Health, Oslo. On 4 November 1975 and 1980, all students in Norway in Grades 7, 8 and 9 (aged 13, 14 and 15) were asked to fill in a questionnaire on smoking habits. Representative samples of these questionnaires were collected for analysis. Sample sizes within each age/sex group ranged from 790 to 947.

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## World Health Organization Policy Objectives

On page 14 of this report, reference is made to policy statements that have been endorsed by the World Health Organization, l'Union Internationale Contre le Cancer and the International Union Against Tuberculosis. These statements constitute an endorsement of the objectives stated in the 1979 Expert Committee Report[1] and quoted below:

"The persistence and increase of the use of tobacco is incompatible with the promotion of good health. Therefore a major human objective is a progressive shrinkage of the tobacco market and the establishment of non-smoking as the normal social behavior.

It is highly desirable that governmental and non-governmental organizations working in the field of smoking control have a co-ordinated international policy. The Committee recommended that these organizations adopt the following policy, which has already been accepted by the Executive Committee of the International Union against Cancer (l'Union Internationale Contre le Cancer) and the Scientific Committee on the Non-Tuberculous Respiratory Diseases of the International Union against Tuberculosis (IUAT):

(1) Achievement of lower smoking rates in all age groups of the population. This implies the application of whatever downward pressures on smoking rates that are practical. These might include health warnings on packets, taxation manipulation, restrictions on smoking opportunities, encouragement of the rights of the non-smoker, as well as measures such as are involved in political, publicity and education programs.

(2) The encouragement of non-smokers to remain non-smokers. The emphasis of this program is on youth.

(3) The cessation of all forms of tobacco promotion.

(4) Those who have not yet stopped smoking, and therefore remain at high risk, should be encouraged to reduce, as far as possible, their exposure to harmful components of tobacco smoke.

(5) To maintain liaison with other health organizations and authorities to ensure maximum effectiveness and avoid conflict of activities.

(6) To achieve public health control of relevant industrial and environmental factors which contribute to lung cancer.

The extra hazards of smoking in certain industrial situations are now known to be such that a combination of restrictions and anti-smoking education programs should be developed."

### Footnote

[1] World Health Organization, *Controlling the Smoking Epidemic, Report of a WHO Expert Committee*, Technical Report Series No. 636 (Geneva: 1979), p. 39.

**Related Documents**

1. Alberta Alcohol and Drug Abuse Commission, *Strategies for a Smoke-Free World, Recommendations of the International Workshop on Smoking and Health to the International Council on Alcohol and Addictions* (Edmonton: 1986).

2. Alberta Alcohol and Drug Abuse Commission, *Strategies for a Smoke-Free World, Selected Resource Documents* (Edmonton: Available August, 1986).

Both of these documents are available at a nominal charge from:

International Council on Alcohol and Addictions
Box 140, CH-1001
Lausanne, Switzerland or

Alberta Alcohol and Drug Abuse Commission
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